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A Defense of Medical Pessimism

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Abstract

This paper presents a philosophical defense of medical pessimism, often termed active euthanasia or "mercy killing," by arguing that in specific clinical contexts, the moral distinction between active and passive euthanasia is untenable. The author critiques the Judeo-Christian and vitalist positions that prioritize the preservation of biological life at all costs, contending that such a stance can lead to an inhumane idolization of mere existence. Through an analysis of arguments from philosophers like James Rachels and within a framework informed by Kantian duty, the paper asserts that the intentional relief of unbearable, intractable suffering can constitute a moral imperative. The central thesis is that once a collective decision has been made that death is the preferable outcome to relentless suffering, the primary moral question shifts from "whether" to allow death to "how" to achieve it most compassionately. The paper concludes by proposing "potential for human relationship" as the key ethical criterion for preserving life, arguing that when this potential is irrevocably lost, the biological continuation of life no longer serves its human purpose, and a compassionate, responsible death becomes ethically permissible.

Keywords: terminally ill, medical vitalism, medical pessimism, mercy killing, active and passive euthanasia.

1. Navigating the extremes of medical ethics

The historical stance of the Judeo-Christian tradition has been to seek a middle path between two opposing medical philosophies: "medical vitalism", which advocates for the preservation of life at any cost, and "medical pessimism," which endorses ending life when it is perceived as burdensome or futile. Despite their apparent opposition, both extremes can be traced to a similar idolization of life a perspective that implicitly frames death as an absolute evil and life as an absolute good. The balanced, traditional view posits that while life is a fundamental and precious good, its value is instrumental; it is the essential condition that makes all other human values and experiences possible. The right to life is therefore primary, as it is the foundational prerequisite for all other rights and duties.

This paper aims to explore the divergent arguments surrounding medical vitalism and medical pessimism, with a particular focus on the latter, often termed "mercy killing" or active euthanasia. This issue presents one of the most agonizing moral dilemmas in modern society. The central question involves the ethical permissibility of intentionally causing a painless death for a patient suffering from an incurable and painful disease. Proponents argue that such an act is not a violation of the right to life, but rather a compassionate substitution of a painful demise with a gentle one, merely shortening an existence that has become unbearable and devoid of value.

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2. Defining the conceptual landscape active vs. passive euthanasia

Active and passive euthanasia

As it has been defined, euthanasia – mercy killing, is where A brings about the death of B, for the sake of B. There are, however, two different ways in which A can bring about B's death: A can kill B by, say administering a lethal injection; or A can allow B to die by withholding or withdrawing life-sustaining treatment. Cases of the first kind are typically referred to as 'active' or 'positive' euthanasia, whereas cases of the second kind are often referred to as 'passive' or 'negative' euthanasia. Active euthanasia occurs when a person actually takes the life of a suffering or dying individual instead of allowing them to die from natural causes. Active euthanasia, therefore, implies a direct action that results to death which is often through giving a lethal injection. And passive euthanasia on the other hand implies an indirect act of killing. Here something is not done and whose absence results to the death of the patient, and this often takes the form of withdrawing life-sustaining treatments. This distinction between active and passive euthanasia is an all-crucial distinction in medical ethics. There has been tremendous controversy and debate over whether ethical distinctions exist between passive and active euthanasia. Some ethics experts contend that it is ethically irrelevant whether a doctor withdraws treatment or gives a lethal injection to end a patient's life because in either case the doctor's intention is to terminate that life. Therefore, they argue that if it is morally permissible to withdraw treatment to terminate a life, then it should be equally acceptable to inject a patient with a lethal dose to accomplish the same objective. As Tom Beauchamp however expressed,

The justification for assistance in bringing about death in medicine is an extension of the justification for letting patients die. Letting a patient die by accepting a valid refusal to continue in life is directly analogous to helping a patient die by accepting a valid request for help.

In his article in *The New England Journal of Medicine*, 1975, James Rachels however, attacks the distinction between active and passive euthanasia, and the doctrine apparently accepted by the American Medical Association that taking direct action to kill a patient (active euthanasia) is wrong, but withholding treatment and allowing a patient to die (passive euthanasia) is allowable. Rachels argues: To begin with a familiar type of situation, a patient who is dying of incurable cancer of the throat is in terrible pain, which can no longer be satisfactorily alleviated. He is certain to die within a few days, even if present treatment is continued, but he does not want to go on living for those days since the pain is unbearable. So, he asks the doctor for an end to it, and his family joins in this request.

Suppose the doctor agrees to withhold treatment … The justification for his doing so is that the patient is in terrible agony, and since he is going to die anyway, it would be wrong to prolong his suffering needlessly. But now notice this. If one simply withholds treatment, it may take the patient longer to die, and so he may suffer more than he would if more direct action were taken and a lethal injection given. This fact provides strong reason for thinking that, once the initial decision not to prolong his agony has been made; active euthanasia is actually preferable to passive euthanasia, rather than the reverse.

Rachels asks, is killing someone worse than letting them die? Consider these two cases: In the first Smith will gain a large inheritance if anything should happen to his young cousin. One evening while the youngster is taking a bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so it will look like an accident. In the second parallel case, Jones will gain a large inheritance and plans to drown his cousin, but as he enters the bathroom Jones sees the child slip and hit his head and fall face down in the water. Jones watches and does nothing.

Now, Smith killed the child while Jones "merely" let the child die. Rachels' question, did either man behave better, from a moral point of view? If the difference between killing and letting die were in itself a morally important matter, one should say that Jones's behavior was less

reprehensible than Smith's. But does one really want to say that? Rachel then states that if the crucial issue in the euthanasia debate is the intentional termination of the life of one human being by another, then how can it be consistent to forbid mercy killing and yet deny that the cessation of treatment is the intentional termination of a life?

What is the cessation of treatment if it is not the "intentional termination of the life of one human being by another"? The so-called distinction between active and passive does not provide a useful moral distinction. This view for the most part is deontological in contrast to a utilitarian or consequentialist view.

However, Rachel's argument is that there is no moral difference between actively killing a patient and passively allowing the patient to die. Thus, it is less cruel for physicians to use active procedures of mercy killing, and he maintains that from a strictly moral standpoint, there is no difference between passive and active euthanasia.

Against the American medical doctrine, Rachels makes three criticisms. First, it results in unnecessary suffering for patients who die slowly and painfully rather than quickly and painlessly. Second, the doctrine leads to moral decisions based on irrelevant considerations. Third, the distinction between killing and letting die assumed by the doctrine is of no moral significance.

Rachel therefore maintains: If a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection for humane reasons. Thus, whether a patient is killed through a direct action or through an indirect act such as withholding treatment according to Rachels is wrong, they do not differ since both have the same outcome: the death of the patient on humanitarian grounds.

There is a widespread agreement that omissions as well as actions can constitute euthanasia. For example, in the Catholic Church's position as expressed in the Sacred Congregation for the Doctrine of the Faith – Declaration on Euthanasia, euthanasia is defined as an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated.

However, philosophical, and ethical disagreement does arise over which actions and omissions amount to euthanasia. Arguably, some people are of the view that a physician practices euthanasia by refraining for instance, from resuscitating a severely brain damaged patient, or a patient in vegetative state, or that a physician engages in euthanasia, when she administers increasingly large doses of a painkilling drug that she knows will eventually result in the patient's death.

Others hold that whenever a physician deliberately and knowingly engages in an action or an omission that results in the patient's foreseen death, the physician has performed active or passive euthanasia. One may then ask, must all available life-sustaining means always be used, or are there certain 'extraordinary' or 'disproportionate' means that need not employed? In essence, if physicians must always do everything possible to try to save life, must active treatment be instigated with regard to terminally ill patients like patients in persistent vegetative state or severely brain damaged patients?

The traditional distinction between 'ordinary' and 'extraordinary' life-sustaining means are today often expressed as 'proportionate' and 'disproportionate' means of treatment. As expressed in the Roman Catholic Church's document, the Sacred Congregation for the Doctrine of the Faith – Declaration on Euthanasia, a means is 'proportionate' if it offers a reasonable hope of benefit to the patient; it is 'disproportionate' if it does not. There is a shared view, even by those who regard euthanasia or the intentional termination of life as always wrong, that there are times when life-sustaining treatment should be withheld.

"The Roman Catholic Church for instance in her declaration thus states:

> When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. In such circumstances the doctor has no reason to reproach himself with failing to help the person in danger."

Following this principle, a physician therefore is bound to use ordinary means of caring for the sick in ordinary medical care setting, ordinary would thus be those which offer reasonable hope of benefit and are not unduly burdensome to either the patient or the family. As Thomas Sullivan also argues, no intentional mercy killing (active or passive) is morally permissible. However, extraordinary means of prolonging life may be discontinued even though the patient's death may be foreseen. Sullivan further argues that most reflective people will agree with Rachels that there is no moral distinction between killing someone and allowing someone to die. According to Sullivan, Rachels's biggest mistake is that he misunderstands the position of the American Medical Association AMA, pointing out that AMA maintains that all intentional mercy killing is wrong, either active or passive.

Although extraordinary procedures for prolonging life may be discontinued for terminally ill patients, these procedures are ones that are both inconvenient and ineffective for the patient. If death occurs more quickly by discontinuing extraordinary procedures, it is only then a by-product. In short, to aim at death (either actively or passively) is always wrong, but it is not wrong to merely foresee death when discontinuing extraordinary procedures. Critics of Rachel focus their arguments on the actual cause of death in the two forms of killing.

Thus, if a patient is allowed to die, isn't that patient killed by the disease? But if someone acts directly to bring about the death of the patient, isn't that person the cause of the patient's death? In this case then he takes the responsibility of the death.

Further in his reply to Rachels, Tom L. Beauchamp argues that one may, of course, be entirely responsible and culpable for another's death either by killing him or by letting him die. In such cases, there is no morally significant difference between killing and letting die precisely because whatever one does, omits, or refrains from doing does not absolve one of responsibility. But not all cases of killing and letting die, he points out fall under this same moral principle. One is sometimes culpable of killing, because morally responsible as the agent for death, as when one pulls the plug on a respirator sustaining a recovering patient (a murder). But one is sometimes not culpable for letting die because one is not morally responsible as agent, as when one pulls the plug on a respirator sustaining an irreversibly comatose and unrecoverable patient (a routine procedure, where one is merely causally responsible).

3. Contextual challenges

Much of the global debate on euthanasia is filtered through a Judeo-Christian moral lens. This paper seeks to situate the problem within the "Nigerian socio-cultural context," acknowledging the reality of medical practice as noted by figures like Lawrence K. Pickett, who stated that allowing hopelessly ill patients to die is an accepted, though often unspoken, medical practice.

We will argue that the "method" of medical pessimism whether active or passive carries no significant moral difference in situations where death has been collectively established as the preferable outcome. This perspective, we contend, is not alien to some traditional African groups, where pragmatic decisions about life and death have historically been made based on communal well-being and resource constraints.

However, discussing medical pessimism ethically is fraught with peril. It can easily be misconstrued as an endorsement of murdering the aged or infirm. Furthermore, in a society like

Nigeria, where material benefits can sometimes unduly influence medical decisions, such a doctrine could be dangerously misapplied. Religious beliefs in the sacredness of life, combined with the potential for a catastrophic increase in crime if euthanasia were poorly regulated, present significant obstacles to its formal adoption.

4. Theological and philosophical counter-arguments

A rational discussion of euthanasia is often hindered by deeply ingrained religious doctrines. An early rejection in Jewish thought is exemplified by Josephus, who, facing defeat, opposed his soldiers' wishes for an honorable suicide. He argued that the soul is a deposit from God, and thus, man acts wickedly in casting it out. Similarly, Thomas Aquinas contended that mercy killing is contrary to natural law and the charity one owes to oneself, constituting a usurpation of God's exclusive authority over life and death.

While these arguments are powerful, a critical examination reveals their limitations. If the disposal of human life is solely God's privilege, then almost every human action that affects lifespan—from life-saving surgery to refusing risky travel could be seen as an encroachment on divine territory. If life is truly a gift from God, then it belongs to the recipient, who may exercise wisdom in its use. When the continued possession of this "gift" becomes more injurious than its surrender, terminating it could be seen as a responsible and compassionate act, consistent with the will of a benevolent God.

This line of reasoning aligns with the philosophical concept of free will. God's role as creator culminates in endowing humans with reason and autonomy. His immanence is expressed through human action and judgment. Therefore, a well-considered decision to end unbearable suffering can be seen as an exercise of divinely-given reason, not a rejection of divine authority.

5. A Kantian framework – Duty, inclination, and compassion

Immanuel Kant's moral philosophy provides a rigorous framework for this discussion. Kant asserts that an action only has moral worth if it is done "for the sake of duty," not from mere inclination or desire. A "good will" acts from a respect for the moral law, an objective standard valid for all rational beings.

The central question then becomes: What is our duty in the face of terminal suffering? Is it the duty to preserve life (medical vitalism) based on its sacredness, or is it the duty to alleviate unbearable suffering (medical pessimism) out of compassion? Critics often conflate a biological "inclination" to survive with a moral "duty" to live at all costs.

This is a misconception. True moral duty, according to Kant, requires treating every rational being as an end in themselves, never merely as a means. This respect for human dignity is the foundation of morality. In this context, compassion understood not as a fleeting emotion but as a profound participation in the suffering of another can be the very basis of a moral duty to act. It is the immediate, non-inclination-driven desire to prevent or eliminate another's agony, forming the real basis for voluntary justice and loving-kindness.

Addressing practical objections and the "wedge argument"

Proponents of medical vitalism raise several practical objections to mercy killing. These include:

The difficulty of ascertaining genuine patient consent.

The risk of misdiagnosis or medical error.

The "wedge argument" (or slippery slope), which posits that legalizing euthanasia would erode society's respect for the sanctity of life, leading to more widespread abuse.

These are serious concerns that demand strict regulation. However, they are not insurmountable. The wedge argument, in particular, is selective in its application. It does not explain why society can condone "wholesale killing in war" without a corresponding erosion of the value placed on life in peacetime. A genuine commitment to the value of human life should lead us to prioritize the wishes, interests, and dignity of every individual in their dealings with the medical system.

6. The nature of moral obligation and the hierarchy of "Good"

Can a moral obligation exist without a direct command from a divine authority? The answer is yes. Moral obligation arises from the intrinsic connection between an act and a necessary moral end. Just as truth compels our intellectual assent, the moral ideal compels our practical consent. We are obligated to perform acts that are necessary means to a necessary good.

For clarity, we can categorize good acts into two types:

1. Obligatory Goods: Acts that "must" be done, as their omission would make the attainment of a necessary end impossible.

2. Non-Obligatory Goods: Acts that may be done, as the end can be achieved through other means; the necessity is not absolute.

In the context of euthanasia, if the relief of extreme, intractable suffering is recognized as a necessary good, and if death is the only means to achieve that relief, then the act could be viewed not as a means to death, but as a means to the end of compassion—a non-obligatory good that is, nevertheless, morally permissible and in some cases, laudable.

7. The "good life" as a prerequisite for value

As philosopher Sidney Hook argued, the value of life is not inherent in mere biological existence. The only life worth living is "the good life." While definitions of a "good life" vary, all conceptions share a common requirement: a basic physical and social foundation. This includes a minimum level of well-being necessary for the pursuit of human relationships, aspirations, and personal dignity.

When this minimum foundation is irretrievably lost, and a patient's existence is reduced to a vegetative state or one of constant degradation and shame, the insistence on preserving life becomes a hollow form of vitalism. In such circumstances, many traditional cultures, including the Ibo culture of Nigeria, hold a noble adage: death is better than a meaningless and vegetative life. There is no categorical imperative simply "to live," but rather "to live well." As David Hume quipped, even the act of dodging a falling stone to save one's life could be seen as "disturbing the course of nature" and defying the lifespan assigned by the laws of physics. The point is that humans are naturally involved in shaping the course of their lives and deaths.

8. A proposed ethical criterion potential for human relationship

Building on this, we conclude that life is not a value to be preserved in and for itself. Such a stance leads to a medical vitalism that is ultimately inhuman. Instead, life is a value to be

preserved precisely because it is the condition for all other values, and only insofar as those other values remain attainable.

Since the most profound human values are rooted in "human relationships, the key criterion for preserving life, as suggested by ethicist Richard A. McCormick, is its "potentiality for human relationships." When, in sound human judgment, this potential is irrevocably lost due to a patient's medical condition, that life can be said to have reached its natural completion. In such a scenario, the biological continuation of life no longer serves its human purpose.

9. Conclusion

Therefore, our view is that once a clinical situation has been legitimately defined as one justifying euthanasia where death is the desired and preferable outcome to relentless, meaningless suffering the critical moral decision has already been made. The debate should then shift from "whether" to allow death to "how" to achieve it most compassionately.

The moral agent, whether physician or family, should choose the course of action that brings about this consequence most effectively and with the least amount of suffering. They must then accept and welcome the responsibility for having chosen the better end. The distinction between active and passive means becomes secondary. In embracing this difficult responsibility, we affirm a commitment to human dignity not just in life, but also in the process of dying, recognizing that a life without the potential for human connection is a life that has fulfilled its natural course.

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